United States Department of Labor
Employees' Compensation Appeals Board

S.H., Appellant	)	
and	)	**Docket No. 15-0845**
	)	**Issued: July 14, 2015**
DEPARTMENT OF THE AIR FORCE, HILL AIR FORCE BASE, UT, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge
ALEC J. KOROMILAS, Alternate Judge

JURISDICTION

On March 4, 2015 appellant, through counsel, filed a timely appeal from a September 16, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has established a permanent impairment of the right or left upper extremity.

FACTUAL HISTORY

On January 24, 2007 appellant, then a 51-year-old electronics mechanic, filed a traumatic injury claim alleging that he sustained carpal tunnel syndrome due to repetitive work in the

[1] 5 U.S.C. § 8101 *et seq.*

course of his federal employment. OWCP accepted the claim for bilateral carpal tunnel syndrome.

An electromyogram (EMG) and nerve conduction studies (NCS) obtained on May 7, 2007 yielded normal findings. They measured distal motor latency of 3.9 milliseconds on the right and 3.3 on the left, and measured distal peak sensory latency of 3.4 milliseconds on the right and 3.1 on the left.

Appellant retired from employment on September 30, 2007.

The record contains no medical evidence from May 24, 2007 until February 23, 2012. On February 23, 2012 Dr. Brent W. Miller, a Board-certified orthopedic surgeon, discussed appellant's history of bilateral carpal tunnel syndrome after performing repetitive work at the employing establishment. He noted that appellant stopped work in 2007, but his symptoms continued and that he currently experienced numbness in the ulnar area of both hands. Dr. Miller stated, "While [appellant] indicates that he was originally diagnosed with bilateral carpal tunnel syndrome, his symptoms certainly at this point tend to point more towards the cubital tunnel or ulnar nerve as the problems."

Electrodiagnostic studies obtained on April 27, 2012 revealed left ulnar neuropathy and mild right carpal tunnel syndrome. The study measured distal motor latency of 4.1 milliseconds on the right and 3.7 milliseconds on the left, and distal peak sensory latency of 3.7 milliseconds on the right and 3.2 milliseconds on the left.

On June 9, 2012 appellant filed a notice of recurrence of a medical condition on January 20, 2012. He listed various jobs that he had held since his retirement, including working as a bartender manager, mower, and plant technician operating a computer controlled paper machine.

On November 21, 2012 appellant underwent a left ulnar nerve release and on December 21, 2012 he underwent a right carpal tunnel release.

By decision dated March 14, 2013, OWCP found that appellant had not established a recurrence of a medical condition. It noted that the EMG obtained prior to his retirement in 2007 was normal and that he had worked in occupations since his retirement that required the use of his upper extremities. Appellant request a hearing and in a decision dated September 9, 2013, an OWCP hearing representative affirmed the March 14, 2013 denial of his recurrence claim.

On September 13, 2013 appellant filed a claim for a schedule award. By letter dated September 16, 2013, OWCP requested that he submit an impairment evaluation from his attending physician in accordance with the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

On October 8, 2013 counsel advised OWCP that appellant' attending physician did not perform impairment evaluations. On October 17, 2013 OWCP referred him to Dr. Michael E. Callahan, a Board-certified orthopedic surgeon, for a second opinion examination to determine the extent and degree of any impairment to a scheduled member.

In an impairment evaluation dated November 8, 2013, Dr. Callahan noted that appellant underwent surgery for left cubital tunnel syndrome on November 21, 2012 and right carpal tunnel syndrome on December 21, 2012. He discussed appellant's work history for the employing establishment and his history of private employment from 2007 to 2013. On examination Dr. Callahan found full range of motion of the upper extremities, normal motor and grip strength, no muscle weakness, and no atrophy of the forearms or hands "including the intrinsic muscles and the thenar and hypothenar eminences." He further found normal two-point discrimination of the right hand and mild sensory changes of the left hand. Dr. Callahan determined that appellant had reached maximum medical improvement on February 11, 2013. Citing Table 15-23 on page 449 of the sixth edition of the A.M.A., *Guides*, he applied a grade modifier of 1 for right carpal tunnel syndrome based on test results showing a conduction delay. Dr. Callahan further applied a grade modifier of 1 for normal physical findings and a grade modifier of 2 for a *Quick*DASH (Disabilities of the Arm, Shoulders, and Hand) score of 43, which yielded a three percent impairment of the right upper extremity due to carpal tunnel syndrome. He further found a three percent impairment of the left upper extremity due to cubital tunnel syndrome under Table 15-23 using the same modifiers.

On December 2, 2013 appellant, through counsel, requested reconsideration of the September 9, 2013 decision finding that he had not established a recurrence of a medical condition.

On February 14, 2014 an OWCP medical adviser reviewed Dr. Callahan's report. He opined that appellant's diagnostic studies did not yield findings sufficient to meet the criteria set forth in the A.M.A., *Guides* at Appendix 15-B on page 487-90 for rating an impairment due to entrapment/compression neuropathy. The medical adviser thus used the wrist regional grade at Table 15-3 on page 395. He identified the diagnosis as bilateral nonspecific wrist pain, which yielded one percent impairment. The medical adviser applied grade modifiers for clinical studies of 1, functional history of 1, and physical examination of 0. Applying the net adjustment formula moved the rating one place to the left, which yielded no impairment of either the right or left upper extremity.

By decision dated February 24, 2014, OWCP denied appellant's claim for a schedule award. It found that the opinion of the medical adviser constituted the weight of the evidence and established that he had no permanent impairment.

In another decision dated February 24, 2014, OWCP denied modification of its September 9, 2013 decision finding that appellant had not established a recurrence of a medical condition.

On February 28, 2014 appellant, through counsel, requested an oral hearing regarding the denial of his schedule award claim.

A hearing was held on July 29, 2014. Counsel argued that a conflict existed between Dr. Callahan and the medical adviser.

By decision dated September 16, 2014, the hearing representative affirmed the February 24, 2014 decision. He found that the medical adviser properly explained that the

electrodiagnostic studies did not show an impairment rating due to entrapment neuropathy under the A.M.A., *Guides*. The hearing representative also noted that Dr. Callahan provided a rating for left cubital tunnel syndrome, which was not accepted by OWCP. He further indicated that OWCP determined that his current right carpal tunnel syndrome was not causally related to his federal employment. The hearing representative concluded that the medical adviser's opinion represented the weight of the evidence.

LEGAL PRECEDENT

The schedule award provision of FECA,[2] and its implementing federal regulations,[3] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[4] As of May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[5]

The A.M.A., *Guides* provides that the diagnosis-based impairment rating is the preferred method for calculating impairment.[6] The sixth edition requires identifying the impairment class for the Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[7] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).

Impairment due to carpal tunnel syndrome is evaluated under the scheme found in Table 15-23 (Entrapment/Compression Neuropathy Impairment) and accompanying relevant text.[8] In Table 15-23, grade modifiers levels (ranging from zero to four) are described for the categories, of clinical studies, functional history, and physical examination. The grade modifier levels are averaged to arrive at the appropriate overall grade modifier level and to identify a default rating value. The default rating value may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities.[9] The maximum impairment rating for

[2] *Id*. at § 8107.

[3] 20 C.F.R. § 10.404.

[4] *Id*. at § 10.404(a).

[5] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.5(a) (February 2013); *see also* Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[6] A.M.A., *Guides* 461.

[7] *Id*. at 494-531.

[8] *Id*. at 449, Table 15-23.

[9] A survey given to a claimant, known as a *Quick*DASH, may be used to determine the function scale score. *Id*. at 448-49.

carpal tunnel syndrome is nine.[10] This section specifically provides that if test findings are grade modifier zero because the electrodiagnostic testing is normal or does not meet standards, then this section is not to be used. The A.M.A., *Guides* provide an appendix for the evaluation of electrodiagnostic evidence of entrapment syndromes.[11] This appendix specifically states that testing must demonstrate distal motor latency longer than 4.5 milliseconds for an 8 centimeter study, that distal peak sensory latency must be longer than 4.0 milliseconds for a 14 centimeter distance and that distal peak compound nerve latency must be longer than 2.4 milliseconds for a transcarpal or midpalmar study of 8 centimeters.

ANALYSIS

OWCP accepted that appellant sustained bilateral carpal tunnel syndrome due to repetitive work duties. Electrodiagnostic testing preformed on May 7, 2007 produced normal results. On September 30, 2007 appellant retired from the employing establishment. Subsequent to his retirement, he worked in a variety of positions in private employment.

On June 9, 2012 appellant filed a notice of recurrence of a medical condition on January 20, 2012 due to his accepted bilateral carpal tunnel syndrome. He underwent a left ulnar nerve release on November 21, 2012 and a right carpal tunnel release on December 21, 2012. In decisions dated March 14 and September 9, 2013 and February 24, 2014, OWCP found that appellant had not established an employment-related recurrence of disability. It did not authorize either surgery.

On September 13, 2013 appellant filed a claim for a schedule award. OWCP referred him to Dr. Callahan for a second opinion examination. On November 8, 2013 Dr. Callahan noted that appellant worked from the employing establishment until 2007 and in private employment thereafter. He found normal range of motion of the upper extremities, normal motor and grip strength, and no atrophy or muscle weakness. Dr. Callahan further found mild sensory changes of the left hand and normal two-point discrimination of the right hand. He rated both extremities using Table 15-23 on page 449, relevant to determining impairment due to entrapment neuropathy. Dr. Callahan applied grade modifiers of 1 for test results and physical findings and a grade modifier of 2 for a *Quick*DASH result of 43, to find a three percent impairment due to right carpal tunnel syndrome and a three percent impairment for left cubital tunnel syndrome. Table 15-23, however, is only applicable if electrodiagnostic testing is abnormal and meets the standards of Appendix 15-B, Electrodiagnostic Evaluation of Entrapment Syndromes.[12] Dr. Callahan did not explain how appellant's test results complied with this standard. Appellant's May 7, 2007 electrodiagnostic testing measured distal motor latency of 3.9 milliseconds on the right and 3.3 on the left, and measured distal peak sensory latency of 3.4 milliseconds on the right and 3.1 on the left. An EMG obtained on April 27, 2012 demonstrated distal motor latency of 4.1 milliseconds on the right and 3.7 milliseconds on the left, and distal peak sensory latency of 3.7 milliseconds on the right and 3.2 milliseconds on the

[10] *Id*. at 449, Table 15-23.

[11] *Id*. at 487.

[12] *Id*.

left. Consequently, the studies did not meet the standards required under Appendix 15-B for showing entrapment neuropathy of measured distal motor latency of 4.5 milliseconds and measured distal peak sensory latency of 4.0 milliseconds.

An OWCP medical adviser reviewed Dr. Callahan's report and determined that the diagnostic studies were insufficient to meet the criteria set forth in the A.M.A., *Guides* for rating an impairment due to entrapment neuropathy. He determined that appellant's wrist condition should be rated for nonspecific wrist pain in accordance with Table 15-3 of the A.M.A., *Guides*. The A.M.A., *Guides* provides that if conduction testing does not meet the diagnostic criteria or have not been performed, there is no ratable impairment due to entrapment neuropathy; however, an impairment may be rated using the diagnosis-based impairments set forth in section 15.2.[13] The medical adviser used the wrist regional grid and identified the diagnosis as bilateral nonspecific wrist pain, for a default value of one percent. He applied grade modifiers for clinical studies and functional history of 1, and physical examination findings of 0. Applying the net adjustment formula (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (1-1) + (0-1) + (1-1) = -1, moved the rating one place to the left, for a zero percent impairment of both the right and left upper extremities.

The Board finds that the opinion of the medical adviser represents the weight of the evidence and establishes that appellant has no impairment of either extremity under the A.M.A., *Guides*. He properly applied the provisions of the A.M.A., *Guides* to the findings of Dr. Callahan. Additionally, the Board notes that if appellant wants to purse entitlement to a schedule award for an impairment as a result of his federal employment, he must submit medical evidence addressing whether any impairment of a scheduled member is causally related to his accepted bilateral carpal tunnel syndrome due to factors of his federal employment.[14] Such an opinion on causal relationship is particularly necessary given his normal electrodiagnostic findings at the time he retired from federal employment in 2007 and his subsequent private employment.

CONCLUSION

The Board finds that appellant has not established that he sustained a permanent impairment of the right or left upper extremity entitling him to a schedule award.

[13] *Id*. at 445-46.

[14] *See Veronica Williams*, 56 ECAB 367 (2005); *Annette M. Dent*, 44 ECAB 403 (1993).

ORDER

IT IS HEREBY ORDERED THAT the September 16, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: July 14, 2015
Washington, DC

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Alec J. Koromilas, Alternate Judge
Employees' Compensation Appeals Board